STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00094324. This visit resulted in a partially extended survey-immediate jeopardy. Complaint IN00094324 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, F226. Unrelated deficiencies are cited Survey dates: August 10, 11, 2011 Extended survey date: August 12, 2011 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Survey team: Ann Armey, RN Census bed type: SNF/NF: 140 Total: 140 Census payor type: Medicare: 7 Medicaid: 105 Other: 28 Total: 140 Sample: 6	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/16/11 by Suzanne Williams, RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to consult	F0157	F 157 Resident # D was assessed, physician was notified, and orders	08/31/2011

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	with the physician regarding the need to continue a treatment that had been discontinued. This deficiency affected 1 of 3 residents, whose treatments were reviewed, in a sample of 6. (Resident #D) Finding include: The clinical record of Resident #D was reviewed on 8/11/11 at 7:00 a.m., and indicated the resident was admitted to the facility on 6/3/11, following the surgical repair of a left hip fracture. Physician orders, dated 7/19/11, indicated "Cleanse area L (Left) heel c (with) N/S (Normal Saline) then apply Xeroform & DCD (Dry Clean Dressing) bid (twice daily). Re-eval (Re-evaluate) in 14 days then rewrite order as needed." The weekly pressure ulcer report indicated the resident was admitted with a pressure ulcer on his left heel and indicated the following: On 7/21/11, the left heel wound was 3 cm by 4.2 cm, and bright pink with a dark scab in the center. The treatment listed was xeroform with dry clean dressing to area. On 8/10/11, the left wound was described as bright pink surrounding a dark center and indicated the treatment continued.		received by physician related to wound treatment. All residents' charts were reviewed, to ensure that residents receiving treatments HAD accurate, CURRENT physician orderS, WITH necessary notification(S) DOCUMENTED in the nurses' notes. All notifications were made and physicians' orders are in place. All licensed nursing staff shall be in-serviced on policy and procedure regarding Condition Change and timely physician notifications, INCLUDING BUT NOT LIMITED TO CONSULTING WITH PHYSICIANS REGARDING THE NEED TO CONTINUE TREATMENTS THAT HAVE BEEN DISCONTINUED PER TIMED ORDER. A performance improvement tool has been developed to monitor treatment records, physician orders, and weekly skin sheets. The audits shall be completed daily, on scheduled days of work, for 30 days by the DNS, ADNS, UM, or designee. Any concerns will be promptly addressed with the responsible individuals. DNS will review findings weekly and report to PI committee monthly for 6 months to determine need for CONTINUED monitoring thereafter.	

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The August 2011 MAR (Medication Administration Record) indicated the twice daily treatment had automatically stopped on 8/2/11 and no other treatment was ordered or documented after that date.

On 8/11/11 at 7:45 a.m., the Wound Nurse was interviewed. The Wound Nurse indicated Resident #D still had a dark scab on his left heel and she continued to cleanse the wound on the left heel, apply xeroform and a dry dressing daily Monday through Friday.
The wound nurse was asked why there was no order for the treatment and no documentation the treatment was done after 8/2/11. The wound nurse stated "That's my fault," and indicated she should have called the physician and had the treatment reordered."

Physician orders, dated 8/11/11, indicated a new treatment order was obtained to cleanse the area on the left heel with normal saline and apply xeroform and a dry clean dressing twice daily until healed.

On 8/12/11 at 4:00 p.m. the area on the left outer heel was observed. The heel was red but blanchable with a small pea-sized brown area present in the center of the

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	wound. 3.1-5(a)(3)			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interviews and record review, the facility failed to assure residents were free from verbal abuse. This deficiency affected 2 of 3 residents, whose allegations of abuse were reviewed, in a sample of 6. (Resident #E and #F) Findings include: 1. The clinical record of Resident #E was reviewed on 8/11/11 at 6:00 a.m., and indicated the resident had diagnoses which included but were not limited to, mental retardation and depression. The MDS (Minimum Data Set) Assessment, dated 5/30/11, indicated Resident #E had moderate cognitive impairment and required extensive assistance for dressing, hygiene and toileting.	F0223	**F 223** 1. CNAs #6 & #7 WERE SUSPENDED AT THE TIME THE ALLEGATIONS OF ABUSE WERE MADE AND INVESTIGATIONS WERE CONDUCTED. BASED ON THE INVESTIGATION FINDINGS, BOTH CNA #6 & #7 WERE TERMINATED FROM EMPLOYMENT. 2. INVESTIGATION WAS CONDUCTED, INCLUDING INTERVIEWS OF STAFF AND RESIDENTS. INVESTIGATION FOR RESIDENT #F WAS INITIATED AS A RESULT OF THE INVESTIGATION FOR RESIDENT #E. 3. THE FACILITY WILL ENSURE THAT ALL ALLEGATIONS OF ABUSE ARE INVESTIGATED AND REPORTED TO THE STATE AGENCIES AS REQUIRED. NURSING CENTER STAFF WILL CONTINUE TO RECEIVE EDUCATION RELATIVE TO ABUSE PREVENTION, INVESTIGATION, AND REPORTING WITH INITIAL	08/13/2011

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	An Alleged Abuse, Neglect and Exploitation Investigation Worksheet, undated, indicated on 7/16/11, "resident states CNA told her she is 'too d...m fat.' Threatened resident 'if you don't stop this crying you are going to eat in your room.' When resident asked for an alternate at meal time, CNA stated 'No, you'll just have to go hungry.' CNA also told resident 'If you don't straighten up you're not going to eat.'" The allegation indicated the resident felt the CNA was rough and did not give her enough time to use the toilet. The allegation further indicated when the resident asked to be pulled up in the chair, "...CNA stated 'if you didn't drink so much d...m Pepsi & (and) coke you could move yourself up.'" The investigation report indicated CNA #6 was removed from the building and suspended on 7/16/11. On 7/17/11 at 3:25 p.m., social services notes indicated Resident #E stated she was talked to inappropriately by a staff person. The note indicated the "Res (Resident) recanted alegation (sic) to SW (Social Worker) exactly how it was reported to E.D. (Executive Director)." Resident #E was "...worried that she will have that caregiver and she will make her eat in her room and go to bed..." The note indicated the resident was reassured she was safe.		EMPLOYEE ORIENTATION AND PERIODICALLY THEREAFTER. A PERFORMANCE IMPROVEMENT TOOL HAS BEEN DEVELOPED TO MONITOR COMPLIANCE WITH ABUSE POLICY AND PROCEDURE RELATED TO INVESTIGATION AND REPORTING ALLEGATIONS OF ABUSE. THE EXECUTIVE DIRECTOR, DIRECTOR OF NURSING SERVICES, ASSISTANT DIRECTOR OF NURSING SERVICES, OR DESIGNEE, WILL COMPLETE AUDIT TOOL FOR 30 DAYS. 4. EXECUTIVE DIRECTOR OR DIRECTOR OF NURSING SERVICES WILL REVIEW FINDINGS WEEKLY AND REPORT TO PI COMMITTEE MONTHLY FOR 6 MONTHS TO DETERMINE NEED FOR CONTINUED MONITORING THEREAFTER.	

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A Performance Improvement form, dated 7/18/11, indicated CNA #6 was discharged for mental and verbal abuse of a resident.

The incident was reported to the ISDH on 7/16/11.

On 8/11/11 at 2:00 p.m., the Administrator indicated verbal abuse was confirmed but CNA #6 never came in for follow-up and resigned.

Review of inservice records indicated CNA #6's last abuse inservice was on 6/6/11.

2. The clinical record of Resident #F was reviewed on 8/11/11 at 5:25 a.m. and indicated the resident was admitted to the facility on 5/8/11 with diagnoses which included, but were not limited to, depressive disorder and cerebral vascular accident.

On 7/1/11 at 3:00 p.m., nursing notes indicated the resident's POA (Power of Attorney) was notified of an abuse allegation and the POA was aware of the investigation taking place.

The facility Incident Reporting Form, undated, indicated, as part of an abuse

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	investigation for another resident on 6/30/11, Resident #F "...reported to (Staff Person's Name) that (CNA #7) refuses to help me, she states 'you need to do things for yourself.' '(Resident's name) you have a bad attitude!' Resident reports this was about a week to 10 days ago, but he did not tell anyone." The report indicated CNA #7 was suspended on 6/30/11 and an investigation was conducted. The report indicated the allegation was substantiated. A performance Improvement Form, dated 7/11/11, indicated the allegation of abuse was substantiated and CNA #7 was terminated on 7/11/11. Review of inservice records indicated CNA #7's last abuse inservice was on 6/6/11. This Federal tag relates to Complaint IN00094324. 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interviews and record review, the facility failed to investigate an allegation of mistreatment, prevent further potential mistreatment and report the allegation of mistreatment to the State	F0225	**F 225** 1. AS IS STATED ON PAGE 6 OF THE 2567, "RESIDENT # B TRANSFERRED TO	08/31/2011

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	survey and certification agency in accordance with State law. This deficiency affected 1 of 3 resident, whose allegations of mistreatment were reviewed, in a sample of 6.(Resident #B) Findings include: On 8/10/11 at 9:10 a.m., the DON (Director of Nursing) was interviewed and indicated there had been an incident involving Resident #B and LPN #8. The DON indicated LPN #8 called her and told her Resident #B was upset with her because she felt she had not administered her breathing treatments appropriately. The DON indicated Resident #B transferred to another facility on 7/29/11. On 8/10/11 at 1:30 p.m., Resident #B was interviewed at her new facility. The resident indicated she had a conflict with LPN #8 regarding her asking aides to go to the kitchen too many times, during meals and she felt "disrespected". The resident indicated, after this she noticed, when LPN #8 gave her breathing treatments, her heart would pound and she would have difficulty breathing. On 7/23/11, she had the same reaction and the nurse told her she was mixing her respiratory treatments. The resident felt the medications should not have been		ANOTHER FACILITY ON 7/29/11", THIS TRANSFER WAS PER RESIDENT REQUEST. THUS, NO FURTHER ACTION COULD BE TAKEN FOR THIS SPECIFIC RESIDENT. RESIDENT # B'S COMPLAINT WAS INVESTIGATED THROUGH THE FACILITY GRIEVANCE PROCEDURE, DUE TO INITIAL ALLEGATION BEING RELATED TO MEDICATION ADMINISTRATION, WITH NO ALLEGATION OF ABUSE STATED. UPON NOTIFICATION OF THE VERBAL ABUSE ALLEGATION, THE EXECUTIVE DIRECTOR INITIATED ANOTHER INVESTIGATION AND IMPLEMENTED FACILITY ABUSE POLICY. NURSE WAS SUSPENDED, ALLEGATION WAS REPORTED TO THE STATE AGENCIES, AND FOLLOWING INVESTIGATION; LPN # 8 WAS TERMINATED.	

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	mixed and this was causing her to have side effects. She felt she should have been sent to the hospital. She spoke to the supervisor and after that, LPN #8 never gave her medications again but she kept coming by her room, smiling. She indicated she talked to the social worker and told her life was in danger and she had to leave the facility. The resident indicated, on the day she left, LPN #8 came into her room to check her roommate's blood sugar and "my heart stopped" because "I was so scared" of her. On 8/10/11 at 2:00 p.m., the DON provided a pharmacy report, dated 8/10/11, indicating giving the two respiratory medications together was not contraindicated and a written statement from the resident's physician, dated 8/10/11, indicating the two respiratory treatments "may cause increased sympathetic activity when administered together but would not cause actual harm to the resident." On 8/10/11 at 3:05 p.m. LPN #8 was interviewed and she indicated she mixed two breathing medications together and Resident #B complained of feeling sick after the treatments. LPN #8 indicated she took the residents vital signs and they were fine. She called the physician, the pharmacy, the Supervisor and the Director		2. ALL RESIDENTS WERE INTERVIEWED TO ENSURE NO OTHER ALLEGATIONS OF ABUSE WERE UNREPORTED. NO OTHER RESIDENTS MADE ALLEGATIONS OF ABUSE. ALL STAFF GRIEVANCES, RESIDENT GRIEVANCES, FAMILY GRIEVANCES, AS WELL AS EVENT REPORTS FROM THE LAST 60 DAYS WERE REVIEWED FOR POTENTIAL ABUSE ALLEGATIONS REQUIRING ABUSE POLICY IMPLEMENTATION. NONE WERE IDENTIFIED. 3. THE FACILITY WILL ENSURE THAT ALL ALLEGATIONS OF ABUSE ARE REPORTED TO THE STATE AGENCIES AS REQUIRED. ALL STAFF WILL BE IN-SERVICED ON ABUSE PREVENTION POLICY AND PROCEDURE, INCLUDING BUT NOT LIMITED TO DEFINITIONS OF ABUSE, AND INVESTIGATIVE /REPORTING PROTOCOLS. A PERFORMANCE	

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	of Nursing to inform them of the situation. The nurse indicated she asked the resident if she wanted to go to the hospital but she declined. She wrote do not mix on the MAR since the resident had a reaction when the medications were mixed. The nurse indicated, after 7/23/11, she never gave Resident #B's medications. On 8/10/11 at 3:30 p.m., the clinical record of Resident #B was reviewed and indicated the resident was admitted to the facility on 7/12/11 with diagnosis which included and were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure, asthma and pneumonia. The MDS (Minimum Data Set) Assessment, dated 7/18/11, indicated the resident had no cognitive impairments. Nursing notes, dated 7/23/11 at 8:00 p.m., indicated the resident complained of sickness and chest pain. The note indicated the vital signs were taken and included; blood pressure of 124/73, heart rate of 89, respiration of 18, temperature of 97.6, and an O2 saturation of 98%. The note indicated the Physician, Director of Nursing and Supervisor were notified. The nursing note indicated the resident did not want to go to the hospital.		IMPROVEMENT TOOL HAS BEEN DEVELOPED TO MONITOR COMPLIANCE WITH ABUSE POLICY AND PROCEDURE RELATED TO INVESTIGATION AND REPORTING ALLEGATIONS OF ABUSE. THE EXECUTIVE DIRECTOR, DIRECTOR OF NURSING SERVICES, ASSISTANT DIRECTOR OF NURSING SERVICES, OR DESIGNEE, WILL COMPLETE AUDIT TOOL FOR 30 DAYS. 4. EXECUTIVE DIRECTOR OR DIRECTOR OF NURSING SERVICES WILL REVIEW FINDINGS WEEKLY AND REPORT TO PI COMMITTEE MONTHLY FOR 6 MONTHS TO DETERMINE NEED FOR CONTINUED MONITORING THEREAFTER.	

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A grievance form, dated 7/26/11, indicated Resident #B stated LPN #8 is "nasty c (with) me at mealtime...she mixes my breathing tx (treatment) together and I am having side effects...(LPN's Name) shows no remorse for mixing tx. (treatment). She still coming in room bothering me. I don't want her in here." The resolution was that other nurses would provide the resident's medication.

A social service note, dated 7/28/11 at 11:00 a.m., indicated she was informed that "res (resident) is very upset, crying in her room and expressed a desire to transfer to another facility...res (resident) began to cry upon writer's entry, stating her nurse 'tried to kill me last week by mixing three treatment together...'....She be (sic) trying to kill me and she's just up in here walking around all day. What you gonna do?....'you know! don't act like you don't know I'm being retaliated against for making a complaint to the DON on her..."

A Resident Transfer Form indicated the resident was transferred to another facility on 7/29/11 at 6:30 p.m.

There was no documentation the allegations of mistreatment were investigated, reported to the ISDH, or that protection was provided to the resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	after the allegation was made. On 8/11/11 at 10:00 a.m., the Scheduler provided a list indicating LPN #8 worked on Resident #B's hall on 7/23/11, 7/24/11, 7/25/11, 7/27/11 and 7/29/11. On 8/11/11 at 11:00 a.m., the Administrator was interviewed. The Administrator indicated the incident was reported to her but the focus was on the medication error. She indicated, on 8/10/11, when she reviewed the documentation from 7/26/11 and 7/28/11, which indicated the resident was fearful and felt the nurse was trying to kill her, she immediately initiated an investigation, suspended the nurse, and reported the allegation to the ISDH. The abuse policies, "Responding to and Investigating an Abuse Allegation, dated 7/22/10 and "Conducting an Investigation", dated 6/30/06, provided by the Administrator and Corporate Nurse, respectively, were reviewed on 8/11/11 at 4:00 p.m. and indicated "Contact the Executive Director and Director of Nursing Immediately....Begin an internal investigation...Report the alleged abuse to the appropriate state agencies in accordance with state law....protect the resident(s) and to prevent a possible reoccurrence during the			

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	155249	A. BUILDING 00 B. WING	08/12/2011

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	investigation (i.e., Immediately removed from any resident contact, Suspension of the accused employee, pending investigation)...." This Federal tag relates to Complaint IN00094324. 3.1-28(c) 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interviews and record review, the facility failed to follow their policy for investigating, reporting, and protecting a resident following an allegation of abuse/mistreatment. This deficiency affected 1 of 3 residents, whose allegations of mistreatment were reviewed, in a sample of 6. (Resident #B) Findings include: On 8/10/11 at 9:10 a.m., the DON	F0226	**F 226** 1. ALTHOUGH RESIDENT # B NO LONGER RESIDES AT THE FACILITY, THE ABUSE POLICY WAS IMPLEMENTED UPON EXECUTIVE DIRECTOR BEING NOTIFIED OF THE ALLEGATION. THE FACILITY HAD ADDRESSED A PREVIOUS CONCERN RELATED TO MEDICATION ADMINISTRATION BY LPN # 8, AS INITIALLY	08/31/2011

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	(Director of Nursing) was interviewed and indicated there had been an incident involving Resident #B and LPN #8. The DON indicated LPN #8 called her and told her Resident #B was upset with her because she felt she had not administered her breathing treatments appropriately. The DON indicated Resident #B transferred to another facility on 7/29/11. On 8/10/11 at 1:30 p.m., Resident #B was interviewed at her new facility. The resident indicated she had a conflict with LPN #8 regarding her asking aides to go to the kitchen too many times, during meals and she felt "disrespected". The resident indicated, after this she noticed, when LPN #8 gave her breathing treatments, her heart would pound and she would have difficulty breathing. On 7/23/11, she had the same reaction and the nurse told her she was mixing her respiratory treatments. The resident felt the		REPORTED, THROUGH THE GRIEVANCE PROCEDURE. STAFF MEMBERS INVOLVED WITH RESIDENT # B'S ALLEGATION HAVE BEEN COUNSELED AND IN-SERVICED RELATED TO ABUSE REPORTING PROCEDURES. 2. ALL RESIDENTS WERE INTERVIEWED TO ENSURE NO OTHER ALLEGATIONS OF ABUSE WERE UNREPORTED. NO FURTHER ALLEGATIONS OF ABUSE WERE COMMUNICATED DURING THIS AUDIT. ALL STAFF GRIEVANCES, RESIDENT GRIEVANCES, FAMILY GRIEVANCES, AS WELL AS EVENT REPORTS FROM THE LAST 60 DAYS WERE REVIEWED FOR POTENTIAL ABUSE ALLEGATIONS REQUIRING ABUSE POLICY IMPLEMENTATION. NONE WERE IDENTIFIED. 3. THE FACILITY WILL ENSURE THAT ABUSE	

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	medications should not have been mixed and this was causing her to have side effects. She felt she should have been sent to the hospital. She spoke to the supervisor and after that, LPN #8 never gave her medications again but she kept coming by her room, smiling. She indicated she talked to the social worker and told her life was in danger and she had to leave the facility. The resident indicated, on the day she left, LPN #8 came into her room to check her roommate's blood sugar and "my heart stopped" because "I was so scared" of her. On 8/10/11 at 2:00 p.m., the DON provided a pharmacy report, dated 8/10/11, indicating giving the two respiratory medications together was not contraindicated and a written statement from the resident's physician, dated 8/10/11, indicating the two respiratory treatments "may cause increased sympathetic activity when administered together but would		POLICY IS IMPLEMENTED TO THE FULL EXTENT OF INTENT TO PROHIBIT MISTREATMENT, NEGLECT AND ABUSE OF RESIDENTS AND MISAPPROPRIATION OF RESIDENT PROPERTY. ALL STAFF WILL BE IN-SERVICED ON ABUSE POLICY AND PROCEDURE INCLUDING BUT NOT LIMITED TO INVESTIGATING, REPORTING, AND PROTECTING RESIDENT FOLLOWING AN ALLEGATION OF ABUSE/MISTREATMENT. A PERFORMANCE IMPROVEMENT TOOL HAS BEEN DEVELOPED TO MONITOR COMPLIANCE WITH ABUSE POLICY AND PROCEDURE. THE EXECUTIVE DIRECTOR, DIRECTOR OF NURSING SERVICES, ASSISTANT DIRECTOR OF NURSING, OR DESIGNEE, WILL COMPLETE AUDIT TOOL FOR 30 DAYS. 4. EXECUTIVE DIRECTOR	

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	not cause actual harm to the resident." On 8/10/11 at 3:05 p.m. LPN #8 was interviewed and she indicated she mixed two breathing medications together and Resident #B complained of feeling sick after the treatments. LPN #8 indicated she took the residents vital signs and they were fine. She called the physician, the pharmacy, the Supervisor and the Director of Nursing to inform them of the situation. The nurse indicated she asked the resident if she wanted to go to the hospital but she declined. She wrote do not mix on the MAR since the resident had a reaction when the medications were mixed. The nurse indicated, after 7/23/11, she never gave Resident #B's medications. On 8/10/11 at 3:30 p.m., the clinical record of Resident #B was reviewed and indicated the resident was admitted to the facility on 7/12/11 with diagnosis which		OR DIRECTOR OF NURSING SERVICES WILL REVIEW FINDINGS WEEKLY AND REPORT TO PI COMMITTEE MONTHLY FOR 6 MONTHS TO DETERMINE NEED FOR CONTINUED MONITORING THEREAFTER.	

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	included and were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure, asthma and pneumonia. The MDS (Minimum Data Set) Assessment, dated 7/18/11, indicated the resident had no cognitive impairments. Nursing notes, dated 7/23/11 at 8:00 p.m., indicated the resident complained of sickness and chest pain. The note indicated the vital signs were taken and included; blood pressure of 124/73, heart rate of 89, respiration of 18, temperature of 97.6, and an O2 saturation of 98%. The note indicated the Physician, Director of Nursing and Supervisor were notified. The nursing note indicated the resident did not want to go to the hospital. A grievance form, dated 7/26/11, indicated Resident #B stated LPN #8 is "nasty c (with) me at mealtime...she mixes my breathing			

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	tx (treatment) together and I am having side effects...(LPN's Name) shows no remorse for mixing tx. (treatment). She still coming in room bothering me. I don't want her in here." The resolution was that other nurses would provide the resident's medication. A social service note, dated 7/28/11 at 11:00 a.m., indicated she was informed that "res (resident) is very upset, crying in her room and expressed a desire to transfer to another facility...res (resident) began to cry upon writer's entry, stating her nurse 'tried to kill me last week by mixing three treatment together...'....She be (sic) trying to kill me and she's just up in here walking around all day. What you gonna do?....'you know! don't act like you don't know I'm being retaliated against for making a complaint to the DON on her..." A Resident Transfer Form indicated the resident was transferred to another facility on 7/29/11 at 6:30			

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	p.m. There was no documentation the allegations of mistreatment were investigated, reported to the ISDH, or that protection was provided to the resident after the allegation was made. On 8/11/11 at 10:00 a.m., the Scheduler provided a list indicating LPN #8 worked on Resident #B's hall on 7/23/11, 7/24/11, 7/25/11, 7/27/11 and 7/29/11. On 8/11/11 at 11:00 a.m., the Administrator was interviewed. The Administrator indicated the incident was reported to her but the focus was on the medication error. She indicated, on 8/10/11, when she reviewed the documentation from 7/26/11 and 7/28/11, which indicated the resident was fearful and felt the nurse was trying to kill her, she immediately initiated an investigation, suspended the nurse, and reported the allegation to the ISDH.			

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	The abuse policies, "Responding to and Investigating an Abuse Allegation, dated 7/22/10 and "Conducting an Investigation", dated 6/30/06, provided by the Administrator and Corporate Nurse, respectively, were reviewed on 8/11/11 at 4:00 p.m. and indicated "Contact the Executive Director and Director of Nursing Immediately....Begin an internal investigation...Report the alleged abuse to the appropriate state agencies in accordance with state law....protect the resident(s) and to prevent a possible reoccurrence during the investigation (i.e., Immediately removed from any resident contact, Suspension of the accused employee, pending investigation)...." This Federal tag relates to Complaint IN00094324. 3.1-28(a)			

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F0323 SS=J	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interviews and record review, the facility failed to prevent a cognitively impaired resident from leaving the facility unattended and failed to assure the safety of the resident when he was initially found outside of the facility. This resulted in the potential for serious harm for 1 of 1 resident, who left the facility unattended, in a sample of 6. (Resident #C) The immediate jeopardy began on 7/5/11, when Resident #C left the facility unattended. The Executive Director, Director of Nursing and Corporate Nurse were notified of the immediate jeopardy on 8/11/11 at 3:30 p.m. The immediate jeopardy was removed on 8/11/11, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The clinical record of Resident #C was reviewed on 8/11/11 at 10:30 a.m. and	F0323	**F 323** The facility requests that this plan of correction be considered its credible allegation of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandate submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction within this	08/13/2011

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	indicated the resident was readmitted from the hospital on 6/30/11, with diagnoses which included, but were not limited to, dementia and end stage renal disease with hemodialysis. The MDS (Minimum Data Set) Assessments, dated 4/26/11 and 7/7/11, indicated resident #C had scores of 10 and 8, respectively, on the BIMS (Brief Interview of Mental Status) indicating the resident had moderate cognitive impairments. The Wander/Elopement Risk Evaluations, dated 4/11/11 and 6/30/11, indicated Resident #C was not an elopement risk. On 7/4/11 at 10:30 a.m., nursing notes indicated Resident #C went out the back therapy door with a vendor. On 8/11/11 at 1:30 p.m., CNA #1 was interviewed regarding the incident. CNA #1 indicated, on 7/4/11, she was sitting at the smoking bench at the back of the building and saw Resident #C standing outside the therapy door by the back parking lot. She approached the resident and redirected him back into the building. The CNA indicated Therapist #2 came to meet them just as they entered the building. On 8/11/11 at 1:35 p.m., Therapist #2 was		timeframe should in no way be construed as admission of guilt or of non-compliance by the facility. I. ***Corrective action taken for resident found to have been affected by the deficient practice:*** Resident # C was returned to the nursing center at 6:10 p.m. on 7/5/11. Resident was assessed for injury upon return to facility, 7/5/11, with none noted. A new Wander/Elopement Risk Evaluation was completed on 7/5/11 for resident. Resident was immediately placed on 1:1 staff monitoring at 6:10 pm, 7/5/11, and showed no additional exit seeking behavior. Resident's physician and family were notified of the event on 7/5/11. An investigation was immediately initiated, 7/5/11. Given that resident stated that he "wanted a pizza", pizza delivery number was posted and was provided to resident on 7/6/11. CNA assignment sheet was updated on 7/6/11. Resident's Behavior Assessment was updated on 7/6/11. Careplan was updated to reflect current interventions. Nutrition Services Manager (NSM) reviewed dialysis nutritional provisions on 7/6/11 with no concerns identified. NSM updated food preferences on 7/6/11. Resident was transferred to the secured Reflections Dementia Unit on 7/9/11 at which time the 1:1 monitoring was discontinued. II. ***Corrective action taken for those***	

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	interviewed regarding the incident. She indicated Resident #C walked out of the facility with a vendor and the vendor went back into the facility and told her a resident had gone out of the door. On 7/5/11 at 5:45 p.m., nursing notes indicated the resident was seen in the assisted dining room. On 7/5/11 at 6:00 p.m., nursing notes indicated Resident #C was seen by an employee outside of the facility by the bus stop. A statement from Speech Therapist #5, who is no longer employed by the facility, dated 7/5/11, indicated: "When I was leaving from work at 5:40 PM on 7/5/11, I saw (Resident #C's name) by (Name of Pharmacy) walking toward Maplecrest Road; so I returned back to the facility & (and) checked with therapy whether he is allowed to be out of the facility for which they said; they did not know: then I went to (MDS Co-ordinators names #3 and #4) about what happened & (and) they went immediately to look for him; I was given a picture of (Resident #C's name) & (and) was asked to check for him in (Name of Pharmacy): I parked my car at (the Pharmacy) parking lot & (and) was about to go in (the Pharmacy) to check ; when I saw (resident's name) walking out of the pizza shop; I crossed		***residents having the potential to be affected by the same deficient practice:*** A facility wide audit was conducted on 7/5/11 at the time of the elopement to ensure all residents were present and accounted for, all residents were accounted for. All exit doors were checked by the Maintenance Director on 7/5/11 with all found to be in working order. Door code was changed on 7/5/11. New Wander/Elopement Risk Evaluations were completed for all residents and verified by the IDT on 7/6/11 to ensure all residents at risk for elopement were identified. CNA assignment sheets were updated on 7/6/11 and careplans were reviewed and updated, as necessary, to reflect current status. Elopement Binders were reviewed and updated on 7/6/11 to include all residents currently at risk for elopement. Door Security Vendor conducted Preventive Maintenance check on all doors & system and verified all to be in working order on 7/6/11. An audit was conducted on 7/6/11 of the Preventive Maintenance tool entitled “Door Security Systems” for the time period of January 2011 through June 2011 with 100% compliance noted, and no concerns noted. Signs were posted at all exit doors on 8/11/11 directing visitors to ensure that no resident exits the facility as they exit. Letters are being sent on	

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	the road & (and) helped him cross the road, got him in my car & (and) got him back into the nursing home/facility." A statement by the DON (Director of Nursing) indicated Resident #C was returned to the facility at 6:00 p.m., and when he was questioned, indicated he went out the side door. On 7/5/11 at 6:10 p.m., nursing notes indicated Resident #C was escorted back into the building and "..when asked how he got out res (resident) said he waited @ (at) the door til it opened..." The note indicated the resident was assessed and placed on one to one supervision. Subsequent nursing notes and monitoring sheets indicated Resident #C remained on one to one supervision through 7/9/11, when he was transferred to the secured unit. The incident was reported to the ISDH on 7/6/11 and the follow up report indicated the following preventive measures were taken: *Resident C's elopement risk evaluation was updated; *Pizza delivery numbers were posted and provided to the resident along with encouragement to request assistance from staff;		8/12/11 to family members/responsible parties and to vendors reminding them to be mindful of ensuring that no resident exits the facility when they are entering or exiting. III. ***The measures put into place and systemic change made to ensure the deficient practice does not recur is:*** Nursing center staff have received re-education relative to facility policy for Resident Elopement, including but not limited to ensuring residents are maintained in a safe situation and the need for immediate initiation of thorough investigation. Education also included “CODE PURPLE” to be utilized in the event a resident is suspected to be missing beginning on 7/5/11 and continuing through 7/7/11. Any employee who was unable to attend, due to PRN status or other reason, has been sent a certified letter. Said employees are not permitted to return to work until in-service education has been completed. Elopement Drills were conducted daily beginning 7/6/2011 through 7/11/11 with good response times noted during the drills. Thereafter, Elopement Drills were scheduled to be conducted ongoing on a monthly basis. The schedule for Elopement Drills has been revised, these drills will be conducted daily for 2 weeks, beginning on 8/11/11 through 8/25/11. Thereafter, Elopement	

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	*The door code was changed by the Maintenance Director, on 7/5/11; *All door alarms were inspected and were in working order; *A door inspection was completed by the door security vendor and the report indicated the elopement was not a result of system failure; *Resident #C's nutritional status was re-assessed to verify needs were being met; *Resident #C's care plan and CNA assignment sheet were updated; *Resident was transferred to the secure unit, on 7/9/11; *All facility residents' elopement risk evaluations, care plans and assignments were updated; *Elopement binders were updated; *Education on elopement policy and the elopement binders was provided to all staff including therapy, housekeeping and laundry staff; *Elopement drills were conducted each day from 7/6/11 through 7/11/11 and will be done monthly for 90 days. *Door security audits were reviewed between 1/11 through 6/11 with 100 percent compliance. *Door security audits were done and reviewed each day between 7/5/11 and 7/11/11. The immediate jeopardy that began on		Drills will be conducted weekly for 30 days, through 9/23/11. Any concerns identified during these drills will promptly be addressed with the responsible individuals. Findings will be provided to the Executive Director for review at monthly Performance Improvement meetings. Maintenance Supervisor completed Preventive Maintenance Tool, “Door Security Systems” daily for the period of 7/5/2011 through 7/11/11, and then weekly for 30 days with 100% compliance noted, and no concerns identified. This PM schedule has been revised, the “Door Security Systems” check will be completed daily for 2 weeks, beginning on 8/11/11 through 8/25/11. Thereafter, the “Door Security Systems” will be conducted weekly for 30 days, through 9/23/11. Any identified concerns/issues will be promptly addressed and corrected. Findings will be provided to the Executive Director for review at monthly Performance Improvement meetings. IV. ***To ensure the deficient practice does not recur, the monitoring system established is***: The Maintenance Supervisor, or designee, shall report to PI monthly all tracking, trending and data analysis related to Elopement Drills and Door Security Systems checks for further recommendations, need for continued monitoring, and or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN46815

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	7/5/11 was removed on 8/11/11, when the facility developed a systematic plan to provide inservice training, elopement drills, security audits, and safety reminder letters to families/vendors, post safety signs at the doors, assess all residents, develop care plans for residents at risk of elopement and develop elopement binders with information regarding procedures and residents. Although the immediate jeopardy was removed, the noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy for residents at risk for elopement because of the need for ongoing monitoring. 3.1-45(a)(2)		resolution. V. ***Completion Date:*** 8.12.11	